DEPARTMENT OF ADMINISTRATIVE SERVICES

DIVISION OF PROFESSIONAL REGULATION

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STATE OF DELAWARE BOARD OF PODIATRY

APPLICATION FOR LICENSURE TO PRACTICE PODIATRIC MEDICINE

TO THE DELAWARE STATE BOARD OF PODIATRY:

I hereby make application for a license to practice Podiatric Medicine in the State of Delaware by: Check (1) or (2).

(1) _____ Direct Licensure
(2) _____ Reciprocity based upon licensure by the states of _____*

1. Name:_____ Day Phone:_____
(Print Name in Full)

Address: _____

_____

Email:_____

2. Social Security Number: _____

3. I received the degree of Doctor of Podiatric Medicine from

_____on
(Name and Location of Institution)

_____.
(Date)

4. Residency or Preceptorship:

_____
(Name and Complete Address of Hospital)

Director _____ Attendance Dates:_____

The qualifications of reciprocity applicants will also be evaluated for eligibility for direct licensure provided the necessary documentation has been submitted. (See application instructions.)

Examinations: List all date(s) on which you took the NBPME Part I, Part II and PMLEXIS examinations and the score(s) received.

Examination	Score	Date of Exam
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please note: Official examination results must be sent directly from the examination service to the Delaware Board of Podiatry.

5. List all states in which you are currently licensed, or have ever held a license to practice podiatry. (Contact each state and request that they complete a written license verification and send to the Delaware Board of Podiatry) ***See application instructions***.

License Number	State	Date Issued	Current/Expired
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

6. List below location and dates of practice including military service.

EMPLOYER/ PRACTICE NAME	ADDRESS WHERE PRACTICED	NATURE OF PRACTICE	DATES OF EMPLOYMENT

7. a. Have you ever held any other Healthcare license? Yes or No (Circle One)

If yes, specify Healthcare license and state(s)_____

_____

b. Has any license above ever been subject to discipline? Yes or No (Circle One)

If yes, explain:_____

_____

8. Have you ever been denied a license to practice podiatric medicine in any state, territory of the United States or the District of Columbia? Yes or No (Circle One)

If yes, identify state or states and reason for denial:_____

_____

9. Has any license entitling you to practice podiatric medicine in any state or territory of the United States ever been suspended, revoked or otherwise subject to discipline or is any such action pending? Yes or No (Circle One)

If yes, provide details including state or territory, charge, date and cause:_____

_____

10. If you have a DEA or State controlled substance number, has your number ever been denied, revoked, suspended or restricted? Yes or No (Circle One)

If yes, provide details including state or territory, charge, date and cause:_____

_____

11 Have you ever had a malpractice judgment or settlement entered against you?
Yes or No (Circle One)

If **yes**, please provide details: _____

_____

12. Are you presently physically and mentally capable of practicing podiatry?
Yes or No (Circle One)

13. Do you have any impairment related to drugs or alcohol, or a finding of mental incompetence by a physician? Yes or No (Circle One).

If yes, please provide details: _____

_____
(If necessary, use a separate sheet and attach to this application.)

14. Have you ever been convicted of a felony? (For purposes of this question, "conviction" shall include pleas of guilty or nolo contendere). Yes or No (Circle One)

If yes, **provide copies of court documents.**

15. Have you ever had <u>any</u> criminal conviction or pending criminal charges (other than traffic offenses) placed against you? (For purposes of this question, "conviction" shall include pleas of guilty or nolo contendere). Yes or No (Circle One)

If yes to either of the above, please explain in detail:_____

_____

16. List hospital staff affiliations and duration. (Give complete address and dates of services.)_____

_____

_____

17. Have your hospital privileges ever been suspended, restricted or rescinded based upon a finding of fraud, deception, illegal, incompetent or negligent practice of podiatry? Yes or No (Circle One)

If yes, please explain:_____

_____

Please note: When your application is <u>complete</u>, please allow 4-8 weeks to receive your license. A <u>complete</u> application is one that includes all required documentation and correct payment.

AFFIDAVIT

This section to be completed in the presence of a notary public

_____ _____

Signature of Applicant Date

STATE OF _____)
) SS
COUNTY OF _____)

The above applicant, _____, being sworn, deposes and says that he or she is attesting that all statements contained in his or her application are true and correct in every respect, and that he or she has not suppressed any information that might affect this application.

Sworn to me before me this _____ day of _____, 20_____.

_____

Signature of Notary Public

My commission expires _____.

(SEAL)